ASIAH KAMSAH

v.

DR RAJINDER SINGH & ORS

HIGH COURT MALAYA, IPOH
JAMES FOONG J
[CIVIL SUIT NO: 21-47-1991]
20 JULY 2001

TORT: *Negligence - Medical negligence - Anaesthetist - Standard of care - Whether liable for patient who suffered brain damage during caesarian operation*

The plaintiff (suing through her brother and next of friend) was admitted to the Telok Intan District Hospital ('the Hospital') to deliver her second child whereupon suspicion of fetus distress she underwent a lower section caesarian operation.

Although the operation was successful with the delivery of a baby boy the plaintiff did not recover from the operation. She suffered permanent irreversible brain damage. The plaintiff claimed damages against the defendants based on two causes of action, *ie*, assault and negligence.

Held:

[1] The plaintiff could not produce any evidence to support her claim in view of her present mental condition, and of all the witnesses summoned by the plaintiff none testified positively that the plaintiff had not given her consent for the operation.

[2] The court believed the two doctors on their positive assertions that consent for the said operation in a written form was seen by them before surgery on the plaintiff was carried out. Just because the form was not found in the hospital file did not necessarily prove that there was no consent given by the plaintiff.

[3] The 2nd defendant had admitted in his evidence that when he saw the plaintiff at the ICU she had brain damage. The court was satisfied that the plaintiff's condition was caused at her operation during the anaesthesia stage.

[4] The plaintiff was running low on oxygen and cyanosis was experienced. Though the 2nd defendant might not have at that stage suspected the plaintiff to suffer bronchospasm, he should have been aware, as an anaesthetist, that aminophyline, the agent to relieve constriction, took time to be effective. When this was the constraint he should "be quick in mind and action" to discover the cause and apply the said drug immediately. The 2nd defendant had failed to do that within this short but critical period.

[Second defendant negligent; 4th defendant vicariously liable; damages awarded.]

Case(s) referred to:
Bolam v. Freirn Hospital Management [1957] 2 All ER 118 ***(refd)***

For the plaintiff - Hira Singh (Anit Kaur); M/s Asbir, Hira Singh & Co
For the defendants - Raja Rozela Raja Toran

Reported by Yow Ting Fong

JUDGMENT

James Foong J:

Introduction

The plaintiff (suing through her brother and next of friend) is a Malay lady of thirty years of age when she was admitted to the Telok Intan District Hospital (the Hospital) to deliver her second child on 10 October 1988. Due to suspicion of fetus distress, she underwent a lower section caesarian operation (LSCS) conducted by one Dr. Karamjeet Singh with the approval of the 1st defendant, Dr. Rajinder Singh, the gynecologist of the Hospital at that time. For this operation she was under general anesthesia applied by the 2nd defendant. Though the operation was successful with the delivery of a baby boy the plaintiff did not fully recover from the operation. She suffered permanent irreversible brain damage.

Her condition as described by one Dr. Fadzli Cheah, a consultant neurosurgeon, who examined her towards the end of 1999, is one of:

> severe permanent mental deficit, cortical blindness and severe spastic quadriparesis. As such, (she) has been rendered totally and permanently disabled requiring complete nursing care at home.

The Plaintiff's Claim

For her injuries, the plaintiff is claiming damages against the defendants. It is based on two causes of action: Assault and negligence. Against the 1st defendant for the vicarious liability of the surgeon, Dr. Karamjeet Singh, who performed the LSCS operation on her. Against the 2nd defendant, for his role as an anaesthetist in the operation. Against the 3rd defendant, as superintendent of the Hospital. Since all these defendants were government servants at that material time, the 4th defendant is inserted as a party to this action.

Defences

The defendants' defences are denials to both assault and negligence.

Analysis

Assault

I shall first deal with the cause of action of assault. This arose from the allegation of the plaintiff of there being an absent of consent given by her for the LSCS operation.

In an operation of this nature, the defendants have not denied that it was the practice of the Hospital at the material time to obtain a written consent from the patient before surgery was carried out. If the patient was incapable to give such consent then this would be secured from the nearest relative.

But in this case, the written consent of the plaintiff or her closest relative for the LSCS operation was not produced. Only a consent by the plaintiff for a lumber puncture was tendered.

Though Dr. Karamjeet Singh and the 2nd defendant have insistently maintained that they have personally seen such a consent signed by the plaintiff before commencement of the operation, this document is just not around in the Hospital file. Thus was there any consent given?

This allegation on the absence of consent to justify a claim by the plaintiff for assault was not in the original plaintiff's statement of claim. This was added during the course of trial when it was discovered that such a document was not contained in the Hospital file. Seizing upon this shortcoming, the plaintiff's counsel mounted this cause of action. But to succeed in such a claim, one must not lose sight that the burden of proof is always with the plaintiff. In this case the plaintiff could not render any evidence to support her claim in view of her present mental condition. So we are firstly deprived of this grantor of consent's evidence: whether she did consent or refused such surgery.

When the best evidence is absent we move on to examine the circumstantial evidence. From all the witnesses summoned by the plaintiff, none of them testified positively that the plaintiff had not given her consent for the operation. PW4, the scrub nurse who said that the operation went without such consent based her testimony solely on the absence of such written consent found in the Hospital document. She did not affirm that the plaintiff never gave her consent. In fact, we have evidence from most quarters that if the operation had not been performed, the plaintiff's uterus would have ruptured, caused by fetus distress, leading to profuse bleeding and ultimate death of the plaintiff. Under such emergency situation, I do not suspect that the plaintiff did not give her consent to the operation. I believed the two doctors – Dr. Karamjeet Singh and the 2nd defendant on their positive assertions that consent for the said operation in a written form was seen by them before surgery on the plaintiff was carried out. Just because such a form is not found in the Hospital file does not necessarily prove that there was no consent given by the patient. All relevant evidence must be taken into consideration and in this case, after due evaluation, I find that such written consent by the plaintiff existed before the operation. For this, the allegation of assault against the defendants must fail.

Negligence

1st Defendant

I shall now move on to the arena of negligence commencing with the allegation against Dr. Karamjeet Singh. Though this particular doctor is not named as a party to this suit but his superior, the 1st defendant is, based on the assertion that the 1st defendant authorised Dr. Karamjeet Singh to carry out such surgery. Thus for the purpose of determining vicarious liability, the acts of Dr. Karamjeet Singh during this operation must be considered.

Despite extensive cross-examination of Dr. Karamjeet Singh by plaintiff's counsel, I find no evidence to support a finding that this doctor was negligent in this surgery going by the test set out in the established case of *Bolam v. Freirn Hospital Management* [1957] 2 All ER 118. The plaintiff must have concurred with this since I find absolutely no reference in the plaintiff's submission commenting on the negligent act of this particular doctor.

When Dr. Karamjeet is not liable for any negligent act relating to the surgical aspect of the plaintiff then the 1st defendant, as head of the gynecological department of the Hospital and the person who gave the approval to Dr. Karamjeet Singh to proceed with the LSCS operation on the plaintiff, should not be liable vicariously.

2nd Defendant
The Events

In the surgical operation performed on the plaintiff, the 2nd defendant was the anesthetist who applied general anesthesia on her. This process, as told by the experts who testified in this trial and accepted by the 2nd defendant involved three (3) stages: induction, maintenance and reversal. Professor Delikan (PW9) from the Department of Anaesthetic of the University Hospital, University of Malaya drew analogy of this to an aircraft on a flight. The initial stage is the preparation for the patient off on an air ride. Once on flight, the anesthetist should maintain the patient; the patient would be on auto-pilot. This is the period when the surgical operation can be performed without the patient being aware of it. When this is over, the patient has to be recovered from the effects of anesthesia. This, the learned Professor likens to a touch down of the airplane. To decide on the issue of liability, I shall examine the different stages undertaken by the 2nd defendant on the plaintiff.

At the commencement of the induction stage, the 2nd defendant administered pure oxygen into the plaintiff for three minutes. This was to boost her reserve as pregnant woman, with a full stomach, often experiences a lower supply of oxygen. Subsequent to this, a drug – Sodium Thiopentone – was applied to render her unconscious. When she was knocked off another agent – Suxamethonium was injected. This was to relax her muscles. For this agent to take effect the 2nd defendant waited for 60 seconds. Once effected, the plaintiff would not be able to breathe on her own. This was necessary for the purpose of intubating an Endotracheal Tube (ETT) into her trachea to connect her to the anesthesia machine. Once the ETT was felt to be in place, the 2nd defendant commenced to pump manually gas from the anesthesia machine into the plaintiff. The gas consisted of a mixture of oxygen and nitrous-oxide. While at this, the 2nd defendant was also listening through a stethoscope to the performance of the plaintiff's lung. At this stage he felt tightness on the pump. This is an indication that the gas was not entering the plaintiff. There was resistance. "After several moments" later he noticed the plaintiff was slightly bluish. Similar sign also appeared in the plaintiff's fingertips. Her heart rate was also getting slower. She was suffering from Cyanosis which is caused by the lack of oxygen (Hypoxia) in the human body. If allowed to persist for too long the brain might swell leading to brain damage. Immediately, according to the 2nd defendant, he administered intravenously a drug called Atropine. This drug would speed up the plaintiff's heart beat. Besides, he turned off the nitrous-oxide in an attempt to allow 100% oxygen to enter the plaintiff's lung. Next he checked the ETT to ensure that it was in the correct place and/or it had not slipped or kink. This was performed manually and with the assistance of Laryngoscope – a tube with a light attached to the end, to be

pushed into the trachea. He discovered constriction in the small airways. The term to describe this is: Bronchospasm. It simply means that the broncho (the breathing tube of the body) had gone into spasm (narrowing) thus preventing gas from the anesthesia machine from going into the plaintiff's lung. Upon discovering this, the 2nd defendant administered a second drug called Aminophyline. This was to relief the constriction in this small area. And, according to him, within several seconds the plaintiff returned to pink with heart rate beating at satisfactory. With these positive indications, he requested Dr. Karamjeet Singh to proceed with the operation.

After surgery was completed, the 2nd defendant reversed the plaintiff. This was by way of two drugs – Neostigmine and Atropine. When these had taken effect, he gave brief commands to which the plaintiff open her eyes. Once satisfied that the plaintiff was breathing on her own, the ETT was removed. With the plaintiff's pulse and heart rate reading at acceptable level and her oxygenation being adequate, instruction was given by the 2nd defendant to transfer the plaintiff to the adjoining Recovery Room. There she remained for approximately 20 minutes before she was given the go-ahead to return to the post-natal ward.

A nurse from the post-natal ward, PW5, came to collect the plaintiff from the Recovery Room. Upon seeing the plaintiff, PW5 was dissatisfied with her condition. She observed that the plaintiff though able to open her eyes but her stares were blank. The plaintiff was in a state of stupor. Besides, her hands were stiff. This nurse initially refused to receive her but upon being informed by the Recovery Room nurse that the 2nd defendant has certified the plaintiff's discharge to the ward she reluctantly pushed the plaintiff off with a protest that she should not be held responsible for any untoward eventualities that may befall upon the plaintiff.

At the ward, still feeling uncomfortable with the plaintiff's condition, PW5 contacted Dr. Karamjeet Singh, who in turn requested the presence of the 2nd defendant. After both these doctors had viewed the plaintiff, she was sent from the post-natal ward to the ICU. There she remained under the charge of the 2nd defendant for two days. Nothing much was done to the plaintiff in the ICU, except observation and assessment. According to the 2nd defendant, the plaintiff was less responsive than the time he discharged her to the Recovery Room.

After two days the plaintiff was once again returned to the post-natal ward without her condition improving. An entry in the Hospital notes states: "refer to Psychiatrist - ? Depression".

Then on 29 October 1988, the plaintiff was sent to the Neurology Department of the General Hospital at Kuala Lumpur where she was treated but her result was not encouraging. With some slight improvement she returned to the Hospital on 12 December 1988 until she was finally discharged on 23 December 1988.

Causation

Dr. Fadzli Cheah who examined the plaintiff on her current condition has confirmed that it was caused by "severe diffused injury to the brain". The 2nd defendant has also admitted in his evidence that when he saw the plaintiff at the ICU she had brain damage. The 2nd defendant then continued to confirm that "she (the plaintiff) suffered complication with anesthetic resulted in some degree of brain damage. Thus she was not able to return to the post-operative stage". With this, I am satisfied that the plaintiff's condition is caused at her operation during anaesthesia stage.

Considerations

In the light of these facts, the plaintiff's counsel insist that the 2nd defendant was negligent at the induction and reversal level of anaesthesia associated with post-operative care.

Induction Stage

At the induction stage, Mr. Hira Singh and Miss Anit Kaur, counsel for the plaintiff impressed upon me that the 2nd defendant had taken longer than an anesthetist of similar experience and standing as the 2nd defendant at that material time to relieve the plaintiff of hypoxia. The 2 to 3 minutes from time of detection of the problem to eventual relief as claimed by the 2nd defendant was challenged. The basis is as follows: Firstly the 2nd defendant had to wait for one full minute before Suxamethonium (the drug which relaxes the muscles) could work. Then, upon discovering cyanosis (discoloring of the body) which could only have been after the initial one minute for Suxamethonium to take effect, time was taken by the 2nd defendant to discover bronchospasm. This must have consumed a good one minute. Upon discovering bronchospasm the drug administered – Aminophyline, which had to be injected slowly according to the 2nd defendant's own evidence, took one to two minutes to act (though Professor Delikan insists that for this agent to react it takes five to ten minutes). Thus the total time consumed by the 2nd defendant could never have been two to three minutes even taking the higher time scale of two minutes (as compared to Professor Delikan's) for Aminophyline to react.

It is essential to bear in mind that this patient was a pregnant woman. Her tolerance to lack of oxygen was less than four minutes. By the time cyanosis was discovered she was already deprived of one minute of oxygen. Presume

the time taken to discover bronchospasm was another minute, two minutes had passed. The administration of Aminophyline would have knock off a few seconds and for it to act, taking the higher scale of time opine by the 2nd defendant of two minutes to the insistence of Professor Delikan of five to ten minutes, this would have absorbed a total of four minutes past. Well past the time limit for the plaintiff to survive without suffering from brain swelling, a secondary of hypoxia, which causes certain degree of brain damage. In fact through persistent cross-examination of the 2nd defendant, the 2nd defendant has admitted that from the time he administered Suxamethonium to the time he corrected the problem, the period taken was "four to five minutes". This, his said "is my estimate". Similarly, the defence own expert witness, DW5, has to concede under cross-examination that 2nd defendant may not be correct when he said that he took two to three minutes from time of detection to time of relief. "I believe two to three minutes is when Dr. Siva (2nd defendant) identified the problem" he continued.

Though the 2nd defendant did not make the deadline to prevent the effects of hypoxia but was he negligent? Under the Bolam test "A doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art" and a "man need not possess the highest at the expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises ordinary skill of an ordinary competent man exercising that particular art … in the case of a medical man negligence means failure to act in accordance with the standard of reasonably competent medical man at that time … there may be one or more perfectly proper standards; and if a medical man conforms with one of these proper standards then he is not negligent" – McNair J in the *Bolam* case.

Undoubtedly, anaesthetic is a special branch of medicine. The 2nd defendant, though possessing no special paper qualification at that material time except that of a MBBS degree, had undergone training to give anesthesia for four to five months at the Ipoh General Hospital. Thereafter he was doing cases on his own. After 16 months at Ipoh General Hospital, where he was trained as an anesthetic and practiced as one, he was transferred to the Hospital. Such in-house training according to Director of Health in the State of Perak, PW7, was sufficient to permit the 2nd defendant to provide anesthesia during an operation. When the 2nd defendant was considered competent to practice this art, then the 2nd defendant's action in this operation must be considered in the light of what a reasonably competent anesthetist would have done during the induction stage of the said operation?

As to the technique applied and drugs administered, from the evidence adduced by the specialist in this field, I do not consider the 2nd defendant has not done what a reasonably competent anesthetist would have done. Though Professor Delikan had insisted that another liquid inhalation agent known as Halothane should have been inserted to relief the bronchospasm, I feel that this is only another technique. But more important to these is the time factor on the application of the technique and administration of the relevant drugs. It was quite pointless to proceed applying the right procedure when there was insufficient regard to time. And this case, time was of the essence. As DW5 candidly admits: "During these few minutes the anesthetist must be quick in mind and action". The patient was running low on oxygen and cyanosis was experienced by the plaintiff. Though the 2nd defendant may not have at that stage suspected the plaintiff to suffer bronchospasm, he should have being aware, as an anesthetist, that Aminophyline, the agent to relieve such constriction takes time to be effective. When this was the constraint he should "be quick in mind and action" to discover the cause and apply the said drug immediately. This, from the accepted standard of practice, I find the 2nd defendant had failed to carry out within this short but critical period.

Reversal Stage Associated With Post-Operative Care

Instead of sending the plaintiff to the ICU after her reversal from anesthesia, the 2nd defendant discharged her from the Recovery Room to the post-natal ward. Was this an accepted standard and practice in view of the plaintiff's condition then? Though signs of successful reversal from anesthesia was from responses of patient, such as the plaintiff opening her eyes upon command, breathing on her own satisfactorily, and other vital signs being positive, her general condition was not acceptable. She could not lift her head and her blank stares of a stupor manner should warrant the 2nd defendant to admit the plaintiff to the ICU. Though the ability to lift her head may not be a criteria of abnormality because many patients do suffer intense pain after surgery and were unable to lift their heads, the plaintiff's general condition was just not right. Added to this, hypoxia was experienced by the plaintiff during induction. As DW5 said: "When one suffers from this (hypoxia) which could lead to cerebral oedema (brain swelling) it would be best to send her to ICU to minimize the effect of cerebral oedema. Sending her to the general ward would have made her condition worse. In ICU, for a patient who had undergone hypoxia in 1988 she would have to be artificially ventilated for 48 hours to minimize the effect of brain swelling…follow up treatment would include treatment to control intra cerebral pressure for a period of time … If the MO (medical officer) lacks knowledge and expertise in any area he should have consulted the consultant. The consultant specialist in the State would know how to follow up such treatment if matter was referred to him." This is also the views of Professor Delikan. But unfortunately, though admitted to the ICU

for 48 hours, no follow up treatment was administered, nor the State anesthetist consultant consulted. The plaintiff's condition had certainly worsened as can be gauged by the 2nd defendant's own observation that the plaintiff at the ICU was less responsive than when he saw her at the Recovery Room.

Post-operative treatment resulting from anaesthesia was the responsibility of the 2nd defendant as the anesthetist in this case. "However" as admitted by the defendants' own witness, DW5, "there was a short fall in the post-operative care of the patient". When this was the situation, I find that the 2nd defendant is guilty of negligence since he did not act in accordance with the practice accepted as proper by a responsible body of medical men skilled in this particular art – a test as set forth in the Bolam case.

Finding On Liability

Based on the aforesaid I hereby firstly dismiss the plaintiff's claim against the 1st defendant. Further, I also dismiss her claim against the 3rd defendant. There is no evidence to prove that the 3rd defendant has been personally liable for the injuries of the plaintiff nor was the Hospital, for which the 3rd defendant was the superintendent, proved to be negligent or had assaulted the plaintiff.

Against the 2nd defendant, I find the cause of action for negligence proved, but not that of assault. As the 2nd defendant at that material time of the accident was an employee of the 4th defendant, the 4th defendant is vicariously liable to the plaintiff for negligence.

Quantum

It is rather unfortunate that defendants' counsel chose not to make any reference during her initial submission on quantum. Despite request, there was also no reply to the plaintiff's submission. This has deprived this court of valuable assistance especially in assessing damages to be awarded. Thus, going by the only authorities submitted by the plaintiff this court makes the following award:

General Damages

For pain, sufferings and loss of amenities, I award a sum of RM200,000. Though the plaintiff's counsel has submitted a claim for blindness, besides brain injury and quadriplegia, I disallow this for reason that this is associated with the latter.

Special Damages

Pre-trial

1. Cost of diapers at RM17.50 x 5 x 11 years	RM 962.50
2. Loss of earnings at RM300 x 12 x 11	RM39,600.00
3. Cost of nursing care for the plaintiff @ RM400 x 12 x 11	RM52,800.00
4. Traveling expenses for relatives to visit the plaintiff at hospitals, cost spend on treatments, purchase of hospitals' and specialist's reports, purchase of a wheel chair	RM 2,880.40
	RM96,242.90

Post trial

1. Loss of future earnings RM300 x 12 x 5 years	RM18,000.00
2. Cost of future nursing care RM400 x 12 x 12 years	RM57,600.00
3. Cost of purchase of diapers RM17.50 x 5 x 12 years	RM 1,050.00
	RM76,650.00

Interest
There shall be:

1. Interest at 4% per annum on general and special damages (pre-trial) from date of issue of writ ie, 10 June 1991 to date of judgment.
2. Interest at 8% per annum on judgment sum from date of judgment to date of realisation.

Cost
Cost is awarded against the 2nd and 4th defendant. The plaintiff shall pay the 1st and 3rd defendants' cost.